



WISCONSIN HOSPITAL  
ASSOCIATION

*A Valued Voice*

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**SUMMARY OF THE PROPOSED  
FFY 2006 MEDICARE  
INPATIENT REHABILITATION  
FACILITY RULE**

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**June 2005**



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## SUBMISSION OF COMMENTS

This document provides an overview of the Medicare proposed rule for the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) for federal fiscal year (FFY) 2006. The Centers for Medicare and Medicaid Services (CMS) must receive comments on the proposal by 5 p.m. on July 18.

CMS requests that comments reference the file code CMS-1290-P and the specific “issue identifier” that precedes the section on which you choose to comment. One original and three copies can be delivered to:

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1290-P  
P.O. Box 8010  
Baltimore, MD 21244-8010

Alternatively, comments (an original and three copies) may be hand-delivered to CMS at:

Room 445-G  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

**OR**

7500 Security Boulevard  
Baltimore, MD 21244-1850  
*Note:* Call (410) 786-7195 to  
schedule the delivery if you  
use the Baltimore address.

CMS is also accepting comments submitted electronically at:  
<http://www.cms.hhs.gov/regulations/ecomments> (attachments should be in Microsoft Word, WordPerfect, or Excel)

## I. OVERVIEW

The Centers for Medicare and Medicaid Services (CMS) published the proposed Medicare Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) rule for federal fiscal year (FFY) 2006 in the May 25 *Federal Register*. Changes are effective October 1, 2005 unless otherwise noted. Where applicable, *Federal Register* page numbers are provided that reference the May 25 IRF PPS proposed rule. Also provided are “issue identifiers” that CMS requests be referenced in your comments.

The current patient classification system was instituted in the August 7, 2001 IRF PPS final rule. CMS indicates that the design of the IRF PPS was based entirely on 1999 data on Medicare rehabilitation patients from a sample of hospitals. CMS states that it now has access to tools that can significantly improve the alignment between Medicare payment and actual IRF costs, noting that data generated by IRFs after the implementation of the IRF PPS are now available for data analysis. The refinements CMS is proposing to make to the IRF PPS are based on the analyses and recommendations from the RAND Corporation. In addition, RAND sought advice from a technical expert panel (TEP), which reviewed RAND’s methodology and findings. As a result of these analyses, CMS is proposing major revisions to the IRF PPS.

## II. STANDARD PAYMENT RATE

Please refer to “Proposed FY 2006 Federal Prospective Payment Rates” if commenting on this issue.

Reimbursement for each IRF discharge is based on a national standard payment rate. For FFY 2006, CMS is proposing to apply a number of adjustments to the standard payment rate.

### **Marketbasket Update** (*Federal Register* page 30222):

The index currently used to update the standard payment rate for IRFs is the excluded hospital including capital marketbasket. This marketbasket is based on 1997 Medicare cost report data and includes Medicare-participating IRFs, long-term care hospitals (LTCHs), inpatient psychiatric facilities (IPFs), cancer, and children’s hospitals.

CMS states that due to lack of data, it is unable to create an IRF-specific marketbasket. Therefore, because nearly all IRFs, LTCHs, and IPFs are paid on a PPS system, CMS is proposing to rebase and revise the marketbasket update for IRFs using a marketbasket reflecting the operating and capital cost structures for IRFs, LTCHs, and IPFs. CMS refers to the proposal as the rehabilitation, psychiatric, long-term care (RPL) marketbasket. CMS is proposing to rebase the RPL marketbasket to 2002 Medicare cost report data, and will exclude children’s and cancer hospitals because of their differing cost structures. The proposed RPL marketbasket update to the standard payment rate for FFY 2006 is 3.1%.

The projected marketbasket using the current FFY 1997-based excluded hospital with capital marketbasket for FFY 2006 is also 3.1%. Table 9 (*Federal Register* page 30233) compares the proposed FFY 2002-based RPL marketbasket and the FFY 1997-based excluded hospital with capital marketbasket percent changes. For both the historical and forecasted periods between FFY 2000 and FFY 2008, the difference between the two marketbaskets is minor.

### **Reduction to the Standard Payment Rate** (*Federal Register* page 30220):

CMS states that implementation of the IRF PPS may have caused changes in case mix because it increased incentives for IRFs to take patients with greater impairment, lower function, or comorbidities. Under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), IRFs were paid on the basis of reasonable costs limited by a facility-specific target amount per discharge without per-discharge adjustments being made for

the impairments, functional status, or comorbidities. According to CMS, IRFs had a strong incentive to admit less costly patients to ensure that the costs of treating patients did not exceed their TEFRA payments. Under the IRF PPS, payments are tied directly to patient characteristics (impairments, functional status, and comorbidities). Therefore, the more costly the patient is expected to be, the higher the PPS payment.

Although CMS states that the IRF PPS likely improved the accuracy and consistency of coding because of educational programs and PPS payments being directly affected by accurate coding, CMS is concerned that changes in coding practices may be increasing IRF payments while not reflecting real changes in case mix. Therefore, CMS is proposing to apply an across-the-board reduction to the standard payment rate of 1.9%.

It should be noted that the proposed reduction is based on a RAND analysis that estimated case mix change due to coding improvement was somewhere in the range of 1.9% to 5.8%.

The IRF PPS proposal does not directly address the “75% rule.” CMS does reference the 75% rule regarding the 1.9% reduction to the standard payment rate (as discussed above). CMS states that “. . . we chose the amount of the proposed reduction in the standard payment amount in order to recognize that IRFs’ current cost structures may be changing as they strive to comply with other recent Medicare policy changes, such as the criteria for IRF classification commonly known as the “75 percent rule.” We are continuing to work with RAND to analyze the data and are soliciting comments on whether the proposed 1.9 percent is the percentage reduction that ought to be made, or if another percentage reduction (for example, the 3.4 percent observed case mix change or the 5.8 percent that RAND found to be maximum amount of change due to coding) should be applied.”

The IRF PPS proposal also does not address the Government Accountability Office (GAO) study of the 13 clinical conditions in the 75% rule. The study found that the rule’s criteria need to be refined, including use of patients’ functional status, but did not recommend adding any more clinical conditions to the 75% rule list. CMS is expected to release a publication regarding the GAO study in the coming days.

CMS is soliciting comments on whether changes that occurred within the transitional IRF PPS rate year could have impacted coding and patient selection and affected the analyses used to create the reduction. CMS is also soliciting comments on the effect of the proposed range of reductions on access to IRF care. CMS further states that this is the first of an ongoing series of studies to evaluate the existence and extent of payment increases due to coding changes and that CMS will continue to review the need for any further reduction in the standard payment amount in subsequent years.

**Budget Neutrality Factors** (*Federal Register* page 30246):

To make the proposed changes to the IRF PPS (as discussed in the text below) in a budget-neutral manner, CMS is proposing to revise the regulations to “. . . provide for the application of a factor, as specified by the Secretary, which would be applied to the standard payment amount in order to make the proposed changes described in this preamble in a budget neutral manner for FY 2006. In addition, this paragraph would be used in future years if we propose refinements to the above-cited adjustments.” Each budget neutrality factor applied to the FFY 2006 standard payment rate is discussed in the text below.

**Calculation of the Standard Payment Rate:**

The following is the calculation of the FFY 2006 standard payment rate.

FFY 2005 standard payment rate = \$12,958

FFY 2006 adjustments:

- proposed RPL marketbasket: 3.1%
- across-the-board reduction: 1.9%
  
- budget neutrality adjustments:
  - wage index changes: .9996
  - CMG changes: .9994
  - teaching adjustment proposal: .9865
  - rural adjustment change: .9963
  - low-income patient (LIP) adjustment change: .9836

FFY 2006 standard payment rate = \$12,658

**III. PATIENT CLASSIFICATION SYSTEM**

Please refer to “Proposed Refinements to the Patient Classification System” if commenting on this issue.

The current IRF PPS is based on federal prospective payment rates across 100 distinct case mix groups (CMGs). CMS defines 21 rehabilitation impairment categories (RICs) as the starting point for CMG classification by identifying the patient’s major diagnostic category requiring rehabilitation. Each of the 21 RICs contains numerous associated impairment groups that further detail the patient’s specific disabling condition within the major category. Once the RIC has been determined, functional independence measures of cognitive and motor status and patient’s age combine to define the 100 CMGs.

CMS further created a tier system that weights comorbidities. Of the 100 CMGs, 95 are further defined into four payment tiers, depending on the presence of certain comorbidities on the discharge assessment. The inclusion of a tiered comorbidity weighting mechanism results in 290 CMG classifications, each of which is assigned a case mix weight. Five special CMGs were constructed to account for very short stays and for patients who expire in the IRF. These CMGs do not have separate weights for presence of comorbidity.

CMS states that they now have access to tools that can significantly improve the alignment between Medicare Payment and actual IRF costs, including:

- the IRF Patient Assessment Instrument (IRF PAI), which provides patient assessment data;
- more recent data, including post-PPS data from 2002 and 2003 that describe the entire universe of Medicare-covered rehabilitation patients; and
- proposed improvements in the algorithms that should lead to new CMGs that better predict treatment costs in the IRF PPS.

CMS is proposing to make the following refinements to the patient classification system. The proposed tier and CMG changes will be implemented in a budget-neutral manner by reducing the standard payment rate by .9994.

### **Comorbidity Updates:**

#### **Changes to the Existing List of Tier Comorbidities** (*Federal Register* page 30194):

Based on analysis that shows 1.6% of FFY 2003 cases received a tier payment that was not justified by any higher cost for the case, CMS is proposing to remove 17 diagnoses considered no longer positively related to treatment cost. CMS is also proposing the removal of two other diagnoses that are either too unspecific to be differentiated from other related codes or unrealistically represented in the data. A table that provides a list of the diagnoses codes to be removed from the tier list can be found on *Federal Register* page 30195.

#### **Moving Dialysis to Tier One** (*Federal Register* page 30195):

Based on analysis indicating that a patient with dialysis costs 31% more than a non-dialysis patient in the same CMG and with the same other accompanying comorbidities, CMS is proposing the movement of dialysis to comorbidity tier one, which is the tier associated with the highest payment and would more closely align payment with the cost of the case. Dialysis is currently in tier two.

#### **Moving Comorbidity Codes Based on Their Marginal Cost** (*Federal Register* page 30196):

CMS believes that the IRF PPS led to substantial changes in coding of comorbidities between 1999 (pre-implementation of the IRF PPS) and 2003 (post-implementation of the IRF PPS). According to CMS, the percentage of cases with one or more comorbidities increased 52% and the presence of a tier one comorbidity, the highest paid of the tiers, almost quadrupled during this same period. CMS notes that although coding likely improved, the presence of “up-coding” for a higher payment may be a factor.

CMS states that costs for several conditions would be more accurately predicted if their tier assignments were changed. Therefore, CMS is proposing to move comorbidity code tier assignments based on their marginal cost according to the results of analyses using 2003 data.

### **CMG Updates:**

#### **Updating the CMGs** (*Federal Register* page 30197):

CMS currently pays IRFs based on CMGs developed using 1999 data. In an attempt to align Medicare payments and actual IRF costs, CMS is proposing to use a new algorithm and FFY 2003 data in constructing the refined CMGs.

CMS identifies the following as the most substantial differences between the existing CMGs and the proposed CMGs:

- fewer CMGs than before (87 compared with 95 in the current system);
- the number of CMGs under the RIC for stroke patients (RIC 1) would decrease from 14 to 10;
- the cognitive index score would affect patient classification in two of the RICs (RICs 1 and 2), whereas it currently affects RICs 1, 2, 5, 8, 12, and 18; and
- a patient's age would now affect assignment for CMGs in RICs 1, 4 and 8, whereas it currently affects assignment for CMGs in RICs 1 and 4.

**Updating the Relative Weights** (*Federal Register* 30212):

Relative weights account for the variance in cost per discharge and resource utilization among payment groups, and are a primary element of a case mix-adjusted PPS. The accuracy of the relative weights helps to ensure that payments reflect as much as possible the relative costs of IRF patients.

Law requires the Secretary, “*from time to time,*” to adjust the classifications and weighting factors to reflect changes in treatment patterns, technology, case mix, number of payment units for which payment to IRFs is made, and other factors which may affect the relative use of resources. Therefore, CMS is proposing to recalculate a relative weight for each CMG based on the availability of more recent data (FFY 2003 Medicare billing data). CMS is not proposing any changes to the methodology for calculating the relative weights, using the same methodology as described in the August 7, 2001 final rule.

**Use of a Weighted Motor Score Index** (*Federal Register* 30210)

Currently, to classify a patient into a CMG, IRFs use the admission assessment data from the IRF-PAI to score a patient’s functional independence measures. The functional independence measures consist of “motor” items and “cognitive” items. The IRF PPS currently uses standard motor and cognitive scores, the sum of either 12 or 13 motor items and the sum of five cognitive items, to assign patients to CMGs. This summing equally weights the components of the indices.

In an attempt to improve the classification of patients into CMGs, and subsequently improve the accuracy of payments to IRFs, CMS is proposing a weighting methodology for the motor score index. The proposed weights (average optimal weights) relate to the functional independent measure (FIM) items’ relative ability to predict treatment costs. CMS is not proposing any changes to the cognitive score index.

The proposed weighting scheme based on the FIM is shown in the table below.

**Proposed Optimal Weights, Averaged Across RICs: Motor Items**

Item Type	Functional Independence Item	Average Optimal Weight
Self	Dressing Lower	1.4
Self	Toilet	1.2
Self	Bathing	0.9
Self	Eating	0.6
Self	Dressing Upper	0.2
Self	Grooming	0.2
Sphincter	Bladder	0.5
Sphincter	Bowel	0.2
Transfer	Transfer to Bed	2.2
Transfer	Transfer to Toilet	1.4
Transfer	Transfer to Tub	Not Included
Locomotion	Walking	1.6
Locomotion	Stairs	1.6

The following equation will now calculate the motor score index:

$$\text{Motor score index} = 1.4*\text{dressing lower} + 1.2*\text{toilet} + 0.9*\text{bathing} + 0.6*\text{eating} + 0.2*\text{dressing upper} + 0.2*\text{grooming} + 0.5*\text{bladder} + 0.2*\text{bowel} + 2.2*\text{transfer to bed} + 1.4*\text{transfer to toilet} + 1.6*\text{walking} + 1.6*\text{stairs}.$$

CMS is further proposing to change the way a code of 0 on the IRF PAI for the transfer to toilet item is treated. CMS is proposing to assign a code of 2, instead of a code of 1, to patients for whom a 0 is recorded on the IRF PAI for the transfer to toilet item. According to CMS, based on calendar year 2002 and FFY 2003 data, patients for whom a 0 is recorded are more similar in terms of their characteristics and costliness to patients with a recorded score of 2 than to patients with a recorded score of 1.

Attachment I compares the CMGs, relative weights, and average length of stay (LOS) from the existing CMGs to the proposed CMGs.

## IV. FACILITY-LEVEL ADJUSTMENTS

Please refer to “Proposed FY 2006 Federal Prospective Payment Rates” if commenting on this issue.

### **Wage Index** (*Federal Register* page 30234):

The IRF PPS adjusts the labor-related portion of the federal prospective payment for differences in area wage levels. The wage index used for the IRF PPS is calculated by using the acute care IPPS wage index data on the basis of the labor market area in which the acute care hospital is located, without taking into account geographic reclassification and without applying the “rural floor.” CMS is proposing to use FFY 2001 acute care hospital wage data for FFY 2006 IRF PPS, the most recent final data available.

The current IRF PPS labor market areas are defined based on Metropolitan Statistical Areas (MSAs) from the 1990 Census. In FFY 2005, CMS implemented revised labor market areas based on the 2000 Census for the inpatient PPS called Core-based Statistical Areas (CBSAs). CMS provided a one-year transition for hospitals that were harmed by the redefinition of the wage index areas, allowing inpatient hospitals experiencing a wage index decrease to receive a blend of 50% of the wage index based on the new definitions and 50% based on the old boundaries. In last year’s IRF PPS update, CMS discussed but did not apply the inpatient PPS redefined labor market areas to the IRF PPS.

CMS is proposing implementation of the revised labor market area definitions based upon the CBSAs adopted in the FFY 2005 inpatient PPS final rule. CMS is proposing to base the IRF PPS wage index on the new wage area definitions without the transitional blend. The proposed changes to the wage index will be implemented in a budget-neutral manner by reducing the standard payment rate by .9996.

### **Labor-Related Share** (*Federal Register* page 30233):

The wage index adjustment is only applied to a portion of the PPS standard rate. This labor-related share is based on an estimate of the national average proportion of IRF operating costs that vary with the local labor market determined using data from the marketbasket calculation. The FFY 2005 labor-related share is 72.359%.

Law requires the Secretary, “*from time to time,*” to adjust the proportion of IRFs costs that are attributable to wages and wage-related costs, of the prospective payment rates. Therefore, CMS is proposing to use the proposed RPL marketbasket costs to determine the proposed labor-related share for the IRF PPS. The proposed labor-related share (including operating and capital) for FFY 2006 is 75.958%.

CMS notes that the calculation of the proposed labor-related share for the IRF PPS is based on the methodology used in the Inpatient PPS. The Inpatient PPS labor-related share methodology is currently under review.

**Low-Income Patient Adjustment** (*Federal Register* page 30245):

Currently, IRFs receive an adjustment to the federal prospective payment rate to account for differences in costs associated with the treatment of low-income patients. Using the latest available data (FFY 2003), CMS is proposing to update the formula used to calculate the LIP adjustment by changing the formula from:

(1 + Disproportional Share Hospital (DSH) patient percentage) raised to the power of .4838  
to  
(1 + DSH patient percentage) raised to the power of .636

The following is an example of the DSH adjustment for an IRF with a DSH percent of 0.10 under the current and proposed formula:

Current DSH formula: (1+ 0.10) raised to the power of .4838 = 4.7% DSH adjustment  
Proposed DSH formula: (1+ 0.10) raised to the power of .636 = 6.2% DSH adjustment

According to CMS, the updated formula using more recent data will better distribute current payments among IRFs. The proposed changes to the LIP adjustment will be implemented in a budget-neutral manner by reducing the standard payment rate by .9836.

**Rural Location Adjustment** (*Federal Register* page 30244):

Currently, IRFs located in rural areas receive a 19.14% add-on to the federal per discharge base rate. Using the latest available data (FFY 2003), CMS found that rural IRFs continue to have higher costs associated with caring for Medicare patients than urban facilities. Therefore, CMS is proposing to increase the add-on for IRFs located in rural areas to 24.1%. The proposed increased adjustment for IRFs located in rural areas will be implemented in a budget-neutral manner by reducing the standard payment rate by .9963.

**Teaching Status Adjustment** (*Federal Register* page 30241):

In the past, CMS has considered, but has not adopted, an adjustment for IRFs that are or are part of teaching institutions to account for the higher indirect operating costs experienced by facilities that participate in Graduate Medical Education programs.

Data that are more recent show that teaching facilities have higher costs associated with caring for Medicare patients than non-teaching facilities. Therefore, CMS is proposing to establish a facility level adjustment to the federal per-discharge base rate for IRFs that are, or are part of, teaching institutions. The proposed teaching status adjustment will be implemented in a budget-neutral manner by reducing the standard payment rate by .9865. This adjustment would be an additional payment to the federal prospective payment rate, similar to the IME payments made under the IPPS and would be made on a claim basis as interim payments, reconciled through the cost report settlement.

The proposed adjustment is based on the ratio of the number of interns and residents assigned to the IRF to the average daily census (ADC) for the IRF. The IRF PPS teaching payment adjustment would be equal to the (1 + resident to ADC ratio) raised to the power of 1.083.

An example of the calculation of the teaching adjustment is shown below. In this case, the IRF would receive a 19.9% increase in the per discharge payment.

IRF ADC = 4,000 (total IRF patient days) / 365 = 10.96  
IRF Resident to ADC Ratio = 2.0 (residents) / 10.96 (calculated ADC) = 0.1825  
IRF Teaching Adjustment = (1 + 0.1825) ^ 1.083 = 1.1990

CMS will establish a cap on the number of IRF residents that is similar to the cap that limits increases in residents under the inpatient PPS. CMS will calculate the “base year” number of residents that trained in the

IRF based on the hospitals most recently filed cost report as of November 15, 2003. Residents with less than full-time status and residents rotating through the IRF for less than a full year will be counted in proportion to the time they spend in their assignment with the IRF. CMS is proposing not to allow IRFs to aggregate the full-time equivalent resident caps used to compute the IRF PPS teaching status adjustment through affiliation agreements. For purposes of determining the teaching adjustment under the IRF PPS, the number of residents cannot exceed the number of residents in the hospital's base year.

Currently, Direct Graduate Medical Education (DGME) payments are provided to teaching hospitals for residents training in the acute hospital and residents training in exempt rehabilitation or psychiatric units. These DGME payments will continue.

## V. CASE-LEVEL ADJUSTMENTS

Please refer to "Proposed FY 2006 Federal Prospective Payment Rates" if commenting on these issues.

### **Transfers:**

A patient discharged from an IRF is considered an early transfer when two conditions are met:

- 1) the length of stay is less than the average length of stay for non-transfer cases in the specific CMG; and
- 2) the patient is discharged to another institutional care setting such as another IRF, an inpatient hospital, long-term care hospital, or a nursing home that accepts Medicare and/or Medicaid payments.

Discharges to home health care, outpatient rehabilitation, or day treatment services are not counted as a transfer for payment purposes, but are treated as part of the normal progression of care and paid a full discharge payment.

Transfer cases are paid a per diem rate that is calculated by dividing the normal case payment for the CMG by the average length of stay for the CMG. The transfer payment amount includes an additional half-day payment for the first day.

CMS has not proposed changes to the current transfer policy.

### **Interrupted Stays:**

An interrupted stay is defined as one in which the beneficiary is discharged and then returns to the facility by midnight of the third day following the discharge; the day of discharge is considered to be day number one. These cases receive only one discharge payment based on the admission assessment from the initial stay.

CMS has not proposed changes to the current interrupted stay policy.

### **Cost Outliers** (*Federal Register* page 30245):

CMS has established an outlier policy for the IRF PPS for cases that require more costly care. The methodology is designed to result in outlier payments that are 3% of total IRF payments. Outlier payments are made for any discharge where the estimated cost of a case (as measured by applying a total facility cost to charge ratio to the charges for the discharge) exceeds the fixed-loss threshold (adjusted CMG payment for the case plus the outlier threshold multiplied by the facility's adjustments). The IRF receives an outlier payment of 80% of the amount over the fixed-loss threshold.

Currently, the outlier threshold is set at \$11,211 above the standard payment amount. Using the latest available data (FFY 2003), CMS is proposing to lower the outlier threshold to \$4,911 above the standard payment amount in FFY 2006 to maintain total outlier payments at 3% of total IRF PPS payments.

CMS indicates that actual 2002 outlier payments were equal to 3.1% of total IRF PPS payments. However, analysis of cost report data indicate that the overall cost-to-charge ratios (CCRs) in IRFs have been falling since the IRF PPS was implemented. Because CCRs are used to determine cases that are eligible for outlier payments, CMS states the drop in the CCRs is likely responsible for much of the drop in total estimated outlier payments below 3% of total estimated IRF PPS payments. CMS is analyzing the reason for this possible finding.

CMS is proposing to continue to apply a ceiling to an IRF's CCR. The proposed CCR ceiling for FFY 2006 is 1.52. CMS is also proposing to update the national urban and rural CCRs for IRFs. These national CCRs are proposed at 0.518 and 0.631 respectively.

## **VI. OTHER**

### **Quality Monitoring** (*Federal Register* page 30191):

Currently, the IRF-PAI contains quality and medical needs questions (collected on a voluntary basis). CMS has contracted with the Research Triangle Institute (RTI) to identify quality indicators pertinent to the IRF setting and determine what information is necessary to calculate those quality indicators. Once RTI has issued a final report, CMS will determine which quality-related items should be listed on the IRF PAI. The revised IRF PAI will need to be approved by the Office of Management and Budget before it is used in IRFs. CMS indicates that any new quality-related data collected from the IRF PAI would have to be analyzed to determine the feasibility of developing a payment method that accounts for the performance of the IRF.

CMS also provides a general discussion of its thinking related to broader initiatives in this area related to quality of care, noting the need to investigate a more coordinated approach to payment and delivery of post-acute services that focuses on the overall post-acute episode. CMS states, "*Medicare should provide payments sufficient to ensure that beneficiaries receive high quality care in the most appropriate setting, so that admissions and any transfers between settings occur only when consistent with good care, rather than to generate additional revenues.*" For a full discussion of this topic area, see *Federal Register* page 30191.

**Attachment I  
Inpatient Rehabilitation Facility Prospective Payment System  
Current Versus Proposed FFY 2006 Case-Mix Group Relative Weights**

CMG	FFY 2002 - FFY 2005 (Current CMGs)									FFY 2006 (Proposed CMGs)								
	CMG Description (M=motor, C=cognitive, A=age)	Relative weights				Average Length of Stay				CMG Description (M=motor, C=cognitive, A=age)	Relative weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
0101	Stroke M=69-84 and C=23-35	0.4778	0.4279	0.4078	0.3859	10	9	6	8	Stroke M>51.05	0.7691	0.7299	0.6484	0.6350	8	11	9	8
0102	Stroke M=59-68 and C=23-35	0.6506	0.5827	0.5553	0.5255	11	12	10	10	Stroke M>44.45 and M<51.05 and C>18.5	0.9471	0.8989	0.7985	0.7820	11	14	11	10
0103	Stroke M=59-84 and C=5-22	0.8296	0.7430	0.7080	0.6700	14	12	12	12	Stroke M>44.45 and M<51.05 and C<18.5	1.1162	1.0594	0.9411	0.9217	13	20	11	12
0104	Stroke M=53-58	0.9007	0.8067	0.7687	0.7275	17	13	12	13	Stroke M>38.85 and M<44.45	1.1859	1.1255	0.9999	0.9792	12	13	13	13
0105	Stroke M=47-52	1.1339	1.0155	0.9677	0.9158	16	17	15	15	Stroke M>34.25 and M<38.85	1.4233	1.3509	1.2001	1.1753	15	16	15	15
0106	Stroke M=42-46	1.3951	1.2494	1.1905	1.1267	18	18	18	18	Stroke M>30.05 and M<34.25	1.6567	1.5724	1.3969	1.3680	16	20	17	17
0107	Stroke M=39-41	1.6159	1.4472	1.3790	1.3050	17	20	21	21	Stroke M>26.15 and M<30.05	1.9121	1.8148	1.6122	1.5790	18	22	19	19
0108	Stroke M=34-38 and A>=83	1.7477	1.5653	1.4915	1.4115	25	27	22	23	Stroke M<26.15 and A>84.5	2.2106	2.0981	1.8639	1.8254	22	23	19	19
0109	Stroke M=34-38 and A<=82	1.8901	1.6928	1.6130	1.5265	24	24	22	24	Stroke M>22.35 and M<26.15 and A<84.5	2.1976	2.0858	1.8529	1.8147	20	23	21	21
0110	Stroke M=12-33 and A>=89	2.0275	1.8159	1.7303	1.6375	29	25	27	26	Stroke M<22.35 and A<84.5	2.6262	2.4926	2.2143	2.1686	23	28	22	23
0111	Stroke M=27-33 and A=82-88	2.0889	1.8709	1.7827	1.6871	29	26	24	27									
0112	Stroke M=12-26 and A=82-88	2.4782	2.2195	2.1149	2.0015	40	33	30	31									
0113	Stroke M=27-33 and A<=81	2.2375	2.0040	1.9095	1.8071	30	27	27	28									
0114	Stroke M=12-26 and A<=81	2.7302	2.4452	2.3300	2.2050	37	34	32	33									
0201	Traumatic brain injury M=52-84 and C=24-35	0.7689	0.7276	0.6724	0.6170	13	14	14	11	Traumatic brain injury M>53.35 and C>23.5	0.8140	0.6826	0.6021	0.5648	10	9	9	8
0202	Traumatic brain injury M=40-51 and C=24-35	1.1181	1.0581	0.9778	0.8973	18	16	17	16	Traumatic brain injury M>44.25 and M<53.35 and C>23.5	1.0437	0.8753	0.7720	0.7241	17	10	11	9
0203	Traumatic brain injury M=40-84 and C=5-23	1.3077	1.2375	1.1436	1.0495	19	20	19	18	Traumatic brain injury M>44.25 and C<23.5	1.2487	1.0472	0.9236	0.8664	13	14	11	12
0204	Traumatic brain injury M=30-39	1.6534	1.5646	1.4459	1.3269	24	23	22	22	Traumatic brain injury M>40.65 and M<44.25	1.3356	1.1201	0.9879	0.9267	14	14	12	12
0205	Traumatic brain injury M=12-29	2.5100	2.3752	2.1949	2.0143	44	36	35	31	Traumatic brain injury M>28.75 and M<40.65	1.6381	1.3738	1.2116	1.1365	16	17	15	14
0206										Traumatic brain injury M>22.05 and M<28.75	2.1379	1.7930	1.5814	1.4833	19	19	18	17
0207										Traumatic brain injury M<22.05	2.7657	2.3194	2.0457	1.9188	28	23	21	20
0301	Non-traumatic brain injury M=51-84	0.9655	0.8239	0.7895	0.7195	14	14	12	13	Non-traumatic brain injury M>41.05	1.1293	0.9536	0.8440	0.7764	12	11	10	10
0302	Non-traumatic brain injury M=41-50	1.3678	1.1672	1.1184	1.0194	19	17	17	16	Non-traumatic brain injury M>35.05 and M<41.05	1.4729	1.2438	1.1008	1.0126	14	15	13	13
0303	Non-traumatic brain injury M=25-40	1.8752	1.6002	1.5334	1.3976	23	23	22	22	Non-traumatic brain injury M>26.15 and M<35.05	1.7575	1.4841	1.3136	1.2083	18	17	15	15
0304	Non-traumatic brain injury M=12-24	2.7911	2.3817	2.2824	2.0801	44	32	34	31	Non-traumatic brain injury M<26.15	2.4221	2.0453	1.8103	1.6651	24	21	19	18
0401	Traumatic spinal cord injury M=50-84	0.9282	0.8716	0.8222	0.6908	15	15	16	14	Traumatic spinal cord injury M>48.45	0.9891	0.8517	0.7656	0.6837	7	12	10	10
0402	Traumatic spinal cord injury M=36-49	1.4211	1.3344	1.2588	1.0576	21	18	22	19	Traumatic spinal cord injury M>30.35 and M<48.45	1.3640	1.1746	1.0558	0.9428	17	16	14	12
0403	Traumatic spinal cord injury M=19-35	2.3485	2.2052	2.0802	1.7478	32	32	31	30	Traumatic spinal cord injury M>16.05 and M<30.35	2.3743	2.0446	1.8379	1.6412	21	22	20	20
0404	Traumatic spinal cord injury M=12-18	3.5227	3.3078	3.1203	2.6216	46	43	62	40	Traumatic spinal cord injury M<16.05 and A>63.5	4.2567	3.6656	3.2950	2.9424	37	36	28	28
0405										Traumatic spinal cord injury M<16.05 and A<63.5	3.2477	2.7967	2.5139	2.2449	25	34	27	24
0501	Non-traumatic spinal cord injury M=51-84 and C=30-35	0.7590	0.6975	0.6230	0.5363	12	13	10	10	Non-traumatic spinal cord injury M>51.35	0.7705	0.6449	0.5641	0.5059	14	7	8	7
0502	Non-traumatic spinal cord injury M=51-84 and C=5-29	0.9458	0.8691	0.7763	0.6683	15	17	10	12	Non-traumatic spinal cord injury M>40.15 and M<51.35	1.0316	0.8634	0.7553	0.6774	13	12	10	9
0503	Non-traumatic spinal cord injury M=41-50	1.1613	1.0672	0.9533	0.8206	17	17	15	14	Non-traumatic spinal cord injury M>31.25 and M<40.15	1.3676	1.1446	1.0013	0.8979	14	15	13	12
0504	Non-traumatic spinal cord injury M=34-40	1.6759	1.5400	1.3757	1.1842	23	21	21	19	Non-traumatic spinal cord injury M>29.25 and M<31.25	1.7120	1.4328	1.2534	1.1240	20	18	15	14
0505	Non-traumatic spinal cord injury M=12-33	2.5314	2.3261	2.0778	1.7887	31	31	29	28	Non-traumatic spinal cord injury M>23.75 and M<29.25	2.0289	1.6981	1.4855	1.3321	20	20	17	16
0506										Non-traumatic spinal cord injury M<23.75	2.7607	2.3106	2.0212	1.8126	21	24	21	20
0601	Neurological M=56-84	0.8794	0.6750	0.6609	0.5949	14	13	12	12	Neurological M>47.75	0.8965	0.7331	0.6966	0.6493	10	10	9	9
0602	Neurological M=47-55	1.1979	0.9195	0.9003	0.8105	15	15	14	15	Neurological M>37.35 and M<47.75	1.1925	0.9752	0.9267	0.8636	13	13	12	12
0603	Neurological M=36-46	1.5368	1.1796	1.1550	1.0397	21	18	18	18	Neurological M>25.85 and M<37.35	1.5266	1.2484	1.1863	1.1056	15	16	14	14
0604	Neurological M=12-35	2.0045	1.5386	1.5065	1.3561	31	24	25	23	Neurological M<25.85	1.9539	1.5979	1.5183	1.4151	17	18	18	17
0701	Fracture of lower extremity M=52-84	0.7015	0.7006	0.6710	0.5960	13	13	12	11	Fracture of lower extremity M>42.15	0.9055	0.7736	0.7285	0.6585	11	11	9	9
0702	Fracture of lower extremity M=46-51	0.9264	0.9251	0.8861	0.7870	15	15	16	14	Fracture of lower extremity M>34.15 and M<42.15	1.1757	1.0044	0.9432	0.8549	13	13	12	11
0703	Fracture of lower extremity M=42-45	1.0977	1.0962	1.0500	0.9326	18	17	17	16	Fracture of lower extremity M>28.15 and M<34.15	1.4636	1.2504	1.1742	1.0643	15	16	15	14
0704	Fracture of lower extremity M=38-41	1.2488	1.2471	1.1945	1.0609	14	20	19	18	Fracture of lower extremity M<28.15	1.7962	1.5345	1.4410	1.3062	16	18	17	16

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0705	Fracture of lower extremity M=12-37	1.4760	1.4740	1.4119	1.2540	20	22	22	21										
0801	Replacement of lower extremity joint M=58-84	0.4909	0.4696	0.4518	0.3890	9	9	8	8	Replacement of lower extremity joint M>49.55	0.6561	0.5511	0.5109	0.4596	7	7	7	6	
0802	Replacement of lower extremity joint M=55-57	0.5667	0.5421	0.5216	0.4490	10	10	9	9	Replacement of lower extremity joint M>37.05 and M<49.55	0.8570	0.7198	0.6673	0.6004	9	10	9	8	
0803	Replacement of lower extremity joint M=47-54	0.6956	0.6654	0.6402	0.5511	9	11	11	10	Replacement of lower extremity joint M>28.65 and M<37.05 and A>83.5	1.2707	1.0672	0.9894	0.8901	17	15	12	11	
0804	Replacement of lower extremity joint M=12-46 and C=32-35	0.9284	0.8881	0.8545	0.7356	15	14	14	12	Replacement of lower extremity joint M>28.65 and M<37.05 and A<83.5	1.1069	0.9296	0.8618	0.7754	13	12	11	10	
0805	Replacement of lower extremity joint M=40-46 and C=5-31	1.0027	0.9593	0.9229	0.7945	16	16	14	14	Replacement of lower extremity joint M>22.05 and M<28.65	1.3937	1.1705	1.0852	0.9763	16	15	13	12	
0806	Replacement of lower extremity joint M=12-39 and C=5-31	1.3681	1.3088	1.2592	1.0840	21	20	19	18	Replacement of lower extremity joint M<22.05	1.6726	1.4047	1.3023	1.1716	15	17	15	14	
0901	Other orthopedic M=54-84	0.6988	0.6390	0.6025	0.5213	12	11	11	11	Other orthopedic M>44.75	0.8412	0.7658	0.6805	0.6090	10	11	10	8	
0902	Other orthopedic M=47-53	0.9496	0.8684	0.8187	0.7084	15	15	14	13	Other orthopedic M>34.35 and M<44.75	1.1054	1.0063	0.8942	0.8002	13	13	12	11	
0903	Other orthopedic M=38-46	1.1987	1.0961	1.0334	0.8942	18	18	17	16	Other orthopedic M>24.15 and M<34.35	1.4583	1.3276	1.1797	1.0557	16	17	15	14	
0904	Other orthopedic M=12-37	1.6272	1.4880	1.4029	1.2138	23	23	23	21	Other orthopedic M<24.15	1.8281	1.6643	1.4788	1.3234	19	20	17	17	
1001	Amputation, lower extremity M=61-84	0.7821	0.7821	0.7153	0.6523	13	13	12	13	Amputation, lower extremity M>47.65	0.9638	0.8888	0.7931	0.7312	11	10	10	10	
1002	Amputation, lower extremity M=52-60	0.9998	0.9998	0.9144	0.8339	15	15	14	15	Amputation, lower extremity M>36.25 and M<47.65	1.2709	1.1719	1.0457	0.9641	14	14	13	12	
1003	Amputation, lower extremity M=46-51	1.2229	1.2229	1.1185	1.0200	18	17	17	18	Amputation, lower extremity M<36.25	1.7876	1.6483	1.4709	1.3561	16	19	17	16	
1004	Amputation, lower extremity M=39-45	1.4264	1.4264	1.3046	1.1897	20	20	19	19										
1005	Amputation, lower extremity M=12-38	1.7588	1.7588	1.6086	1.4670	21	25	23	23										
1101	Amputation, non-lower extremity M=52-84	1.2621	0.7683	0.7149	0.6631	18	11	13	12	Amputation, non-lower extremity M>36.35	1.2544	1.0496	0.9189	0.8462	13	14	11	11	
1102	Amputation, non-lower extremity M=38-51	1.9534	1.1892	1.1064	1.0263	25	18	17	18	Amputation, non-lower extremity M<36.35	1.8780	1.5713	1.3756	1.2668	16	16	16	15	
1103	Amputation, non-lower extremity M=12-37	2.6543	1.6159	1.5034	1.3945	33	23	22	25										
1201	Osteoarthritis M=55-84 and C=34-35	0.7219	0.5429	0.5103	0.4596	13	10	11	9	Osteoarthritis M>37.65	1.0184	0.8794	0.8106	0.7317	11	12	11	10	
1202	Osteoarthritis M=55-84 and C=5-33	0.9284	0.6983	0.6563	0.5911	16	11	13	13	Osteoarthritis M>30.75 and M<37.65	1.3181	1.1383	1.0492	0.9470	13	15	13	13	
1203	Osteoarthritis M=48-54	1.0771	0.8101	0.7614	0.6858	18	15	14	13	Osteoarthritis M<30.75	1.6238	1.4022	1.2925	1.1666	17	16	16	15	
1204	Osteoarthritis M=39-47	1.3950	1.0492	0.9861	0.8882	22	19	16	17										
1205	Osteoarthritis M=12-38	1.7874	1.3443	1.2634	1.1380	27	21	21	20										
1301	Rheumatoid, other arthritis M=54-84	0.7719	0.6522	0.6434	0.5566	13	14	13	11	Rheumatoid, other arthritis M>36.35	1.0338	0.9617	0.8325	0.7358	11	12	11	10	
1302	Rheumatoid, other arthritis M=47-53	0.9882	0.8349	0.8237	0.7126	16	14	14	14	Rheumatoid, other arthritis M>26.15 and M<36.35	1.4324	1.3325	1.1534	1.0195	15	17	14	13	
1303	Rheumatoid, other arthritis M=36-46	1.3132	1.1095	1.0945	0.9469	20	18	16	17	Rheumatoid, other arthritis M<26.15	1.8308	1.7032	1.4743	1.3032	18	19	17	16	
1304	Rheumatoid, other arthritis M=12-35	1.8662	1.5768	1.5555	1.3457	25	25	29	22										
1401	Cardiac M=56-84	0.7190	0.6433	0.5722	0.5156	15	12	11	11	Cardiac M>48.85	0.8172	0.7352	0.6396	0.5806	9	9	9	8	
1402	Cardiac M=48-55	0.9902	0.8858	0.7880	0.7101	13	15	13	13	Cardiac M>38.55 and M<48.85	1.1034	0.9926	0.8636	0.7839	11	13	11	10	
1403	Cardiac M=38-47	1.2975	1.1608	1.0325	0.9305	21	19	16	16	Cardiac M>31.15 and M<38.55	1.3735	1.2356	1.0750	0.9759	14	15	13	12	
1404	Cardiac M=12-37	1.8013	1.6115	1.4335	1.2918	30	24	21	20	Cardiac M<31.15	1.7419	1.5671	1.3633	1.2376	17	18	15	14	
1501	Pulmonary M=61-84	0.8032	0.7633	0.6926	0.6615	15	13	13	13	Pulmonary M>49.25	0.9222	0.8995	0.7687	0.7397	8	12	10	10	
1502	Pulmonary M=48-60	1.0268	0.9758	0.8855	0.8457	17	17	14	15	Pulmonary M>39.05 and M<49.25	1.1659	1.1371	0.9718	0.9352	11	14	12	12	
1503	Pulmonary M=36-47	1.3242	1.2584	1.1419	1.0906	21	20	18	18	Pulmonary M>29.15 and M<39.05	1.4269	1.3917	1.1894	1.1445	11	15	14	14	
1504	Pulmonary M=12-35	2.0598	1.9575	1.7763	1.6965	30	28	30	26	Pulmonary M<29.15	1.8812	1.8348	1.5681	1.5089	18	18	16	14	
1601	Pain syndrome M=45-84	0.8707	0.8327	0.7886	0.6603	15	14	13	13	Pain syndrome M>37.15	1.0065	0.8544	0.7731	0.6904	12	10	10	9	
1602	Pain syndrome M=12-44	1.3320	1.2739	1.2066	1.0103	21	20	20	18	Pain syndrome M>26.75 and M<37.15	1.3810	1.1724	1.0607	0.9473	12	16	13	12	
1603										Pain syndrome M<26.75	1.6988	1.4421	1.3048	1.1653	18	17	15	14	
1701	Major multiple trauma without brain or spinal cord injury M=46-84	0.9996	0.9022	0.8138	0.7205	16	14	11	13	Major multiple trauma without brain or spinal cord injury M>39.25	1.0102	0.9634	0.8323	0.7321	12	11	11	10	
1702	Major multiple trauma without brain or spinal cord injury M=33-45	1.4755	1.3317	1.2011	1.0634	21	21	20	18	Major multiple trauma without brain or spinal cord injury M>31.05 and M<39.25	1.3305	1.2688	1.0962	0.9643	14	16	14	13	
1703	Major multiple trauma without brain or spinal cord injury M=12-32	2.1370	1.9288	1.7396	1.5402	33	28	27	24	Major multiple trauma without brain or spinal cord injury M>25.55 and M<31.05	1.5832	1.5098	1.3043	1.1474	16	19	16	15	
1704										Major multiple trauma without brain or spinal cord injury M<25.55	1.9808	1.8889	1.6319	1.4355	23	22	19	17	
1801	Major multiple trauma with brain or spinal cord injury M=45-84 and C=33-35	0.7445	0.7445	0.6862	0.6282	12	12	12	10	Major multiple trauma with brain or spinal cord injury M>40.85	1.2118	0.9832	0.8245	0.7282	20	16	12	9	
1802	Major multiple trauma with brain or spinal cord injury M=45-84 and C=5-32	1.0674	1.0674	0.9838	0.9007	16	16	16	16	Major multiple trauma with brain or spinal cord injury M>23.05 and M<40.85	1.9385	1.5728	1.3190	1.1649	20	21	17	15	
1803	Major multiple trauma with brain or spinal cord injury M=26-44	1.6350	1.6350	1.5069	1.3797	22	25	20	22	Major multiple trauma with brain or spinal cord injury M<23.05	3.4784	2.8222	2.3668	2.0903	30	25	25	22	
1804	Major multiple trauma with brain or spinal cord injury M=12-25	2.9140	2.9140	2.6858	2.4589	41	29	40	40										

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1901	Guillian Barre M=47-84	1.1585	1.0002	0.9781	0.8876	15	15	16	15	Guillian Barre M>35.95	1.2362	1.0981	1.0677	0.9349	12	14	13	12
1902	Guillian Barre M=31-46	2.1542	1.8598	1.8188	1.6505	27	27	27	24	Guillian Barre M>18.05 and M<35.95	2.3162	2.0574	2.0004	1.7515	28	24	22	22
1903	Guillian Barre M=12-30	3.1339	2.7056	2.6459	2.4011	41	35	30	40	Guillian Barre M<18.05	3.3439	2.9703	2.8881	2.5287	27	29	25	27
2001	Miscellaneous M=54-84	0.8371	0.7195	0.6705	0.6029	12	13	11	12	Miscellaneous M=49.15	0.8743	0.7387	0.6623	0.6047	9	10	9	8
2002	Miscellaneous M=45-53	1.1056	0.9502	0.8855	0.7962	15	15	14	14	Miscellaneous M>38.75 and M<49.15	1.1448	0.9672	0.8671	0.7917	12	12	11	10
2003	Miscellaneous M=33-44	1.4639	1.2581	1.1725	1.0543	20	18	18	18	Miscellaneous M>27.85 and M<38.75	1.4789	1.2495	1.1202	1.0227	15	15	14	13
2004	Miscellaneous M=12-32 and A>=82	1.7472	1.5017	1.3994	1.2583	30	22	21	22	Miscellaneous M<27.85	1.9756	1.6692	1.4964	1.3663	19	18	17	15
2005	Miscellaneous M=12-32 and A<=81	2.0799	1.7876	1.6659	1.4979	33	25	24	24									
2101	Burns M=46-84	1.0357	0.9425	0.8387	0.8387	18	18	15	16	Burns M>0	2.1858	2.1858	1.5910	1.4762	26	20	17	16
2102	Burns M=12-45	2.2508	2.0482	1.8226	1.8226	31	26	26	29									
5001	Short-stay cases, length of stay is 3 days or fewer	N/A	N/A	N/A	0.1651	N/A	N/A	N/A	3	Short-stay cases, length of stay is 3 days or fewer				0.2201				2
5101	Expired, orthopedic, length of stay is 13 days or fewer	N/A	N/A	N/A	0.4279	N/A	N/A	N/A	8	Expired, orthopedic, length of stay is 13 days or fewer				0.6351				8
5102	Expired, orthopedic, length of stay is 14 days or more	N/A	N/A	N/A	1.2390	N/A	N/A	N/A	23	Expired, orthopedic, length of stay is 14 days or more				1.6002				22
5103	Expired, not orthopedic, length of stay is 15 days or fewer	N/A	N/A	N/A	0.5436	N/A	N/A	N/A	9	Expired, not orthopedic, length of stay is 15 days or fewer				0.7204				8
5104	Expired, not orthopedic, length of stay is 16 days or more	N/A	N/A	N/A	1.7100	N/A	N/A	N/A	28	Expired, not orthopedic, length of stay is 16 days or more				1.8771				24